Weymouth Public School Health Services

Written Parental/Guardian Consent for Medication Administration in School
****ALL MEDICATIONS AND ORDERS MUST BE DELIVERED DIRECTLY TO THE NURSE****

Student Name:	Date of Birth:	M or F or Other
Address:	School:	Grade:
Parent/Guardian:	Home:	Cell:
EMERGENCY CONTACT:	Home:	Cell:

Please list all medications the child receives, including any given during school hours.

1.	2.	3.

My child has known allergies to:

(Please List)

Any specific administration directions:	
Possible side effects/adverse reactions:	

Consent **(please circle yes or no)**

Consent for Medication Administration:	**Yes or No**
I give my child permission the **self administer** medication (if deemed safe and appropriate by School Nurse)	**Yes or No**
Plans for self administration and monitoring of medication attached?	**Yes or No**
I give permission to the school nurse to share with appropriate school staff member information relative to the prescribed medication administration (e.g. adverse side effects) that the nurse determines necessary for my child's health and safety:	**Yes or No**
*****Please note any and all restrictions for access to private health information*******	

***** PLEASE NOTE: I understand that I may retrieve the medication from the school nurse at any time and that the medication will be destroyed if it is not picked up by the last day of the school year, or within one week following the discontinuation of the medication order, or of the student leaving the school in which they are currently enrolled******

Parent/Guardian Signature:____ **Date:**____________________